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Reply to the Editor:

We thank Hirose and Amano for their comments, and we are encouraged that they report a similarly low risk of sternal wound infection in patients with diabetes who received bilateral skeletonized internal thoracic artery (ITA) grafts. Several additional studies have evaluated the safety of bilateral skeletonized ITA grafts in patients at high risk for sternal wound infection.[1,2] All these studies have reported a low incidence of sternal wound infection in patients with diabetes. However, we do caution against generalizing these results to patients with diabetes who have multiple risk factors for sternal infection such as obesity, peripheral vascular disease, and chronic obstructive pulmonary disease.

Hirose and Amano suggest that harvesting of skeletonized ITAs with an ultrasonic scalpel reduces the risk of graft injury and lowers the time required for dissection. Higami and colleagues[3] described skeletonization of ITAs with an ultrasonic scalpel; they reported harvesting times of 20 to 25 minutes, similar to pedicled harvesting. Provided the ITA side branches are sectioned at a distance of 1 mm from the main ITA trunk, the use of an ultrasonic scalpel appears safe.[4] We do not currently use an ultrasonic scalpel at our institution and therefore cannot comment more specifically on this technique. However, we definitely believe that meticulous dissection of ITA grafts, regardless of the technique used, results in a low risk of graft injury.

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Saphenectomy wound complications: The real story

To the Editor:

Olsen and colleagues,[1] in a recent retrospective analysis, have suggested that the Society of Thoracic Surgeons database is a useful tool for tracking saphenous vein harvest site infections and determining predictors for this complication. They report a 4.5% wound complication rate after traditional open saphenectomy in 1980 patients undergoing coronary artery bypass grafting from 1996 through 1999. Although their article may accurately report wound complications identified while the patient is in the hospital, it is unlikely they capture the vast majority of leg wound complications, because most occur after discharge. They cite poor outpatient follow-up as a potential limitation of their study; however, their article fails to site published, prospectively collected data on this topic. Two prospective studies, by Allen and coworkers[2] and Utley and associates,[3] have evaluated longitudinal saphenectomy wound complications after coronary artery bypass grafting with the same wound complication definition and independent assessment, including outpatient follow-up. They reported complication rates of 19% and 24%, respectively, which are much higher then observed in this retrospective series.

Contrary to the discussion by Olsen and colleagues,[1] endoscopic vein harvest as a means of reducing leg wound complications has been validated by more than one prospective, randomized trial, and it has consistently been shown to be superior regarding wound complications relative to an open harvest technique. In the first prospective, randomized comparison of endoscopic versus longitudinal saphenectomy, endoscopic vein harvest was associated with a significant reduction in leg wound complications (4% vs 19%, respectively).[2] Unfortunately, that 1998 article was missed during the literature search for the article of Olsen and colleagues.[1] Furthermore, traditional saphenectomy has been identified as an independent predictor for leg wound complications, and the use of endoscopic vein harvest modifies the impacts of diabetes, peripheral vascular disease, female gender, and obesity as risk factors for development of leg wound complications.[4] Olsen and colleagues are to be applauded for continuing to bring the problem of saphenectomy wound complications to the attention of cardiac surgeons. They do a disservice, however, by publishing a 4.5% complication rate that underestimates the true scope of this problem. Databases such as that of the Society of Thoracic Surgeons do an excellent job of tracking events while patients are hospitalized; however, their ability to track events that occur and are managed on an outpatient basis is less reliable.

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